Massachusetts Department of Public Health
Request for Amendment of Confidential Information

Name: _____

Address: _____

Phone # _____ Date of Birth: ___/ ___/ ___

After review of my record, I do not feel that the original documentation made on the date(s) _____ is accurate, and should be supplemented with clarifying information in the form of an addendum to my record.

I request the following correction/amendment be made to my record (attach additional documents if necessary):

_____

_____

_____

_____

_____

_____

- I understand that the original documentation in my record will not be altered, and that if any changes are agreed to they will be recorded in an addendum to my record. A copy of the addendum will be provided to me.
- I understand that my request for amendment will be made a permanent part of my record and will be sent with any future authorized record request for information.
- I understand that DPH may decide not to amend my record based on my request, and if so it will provide me with the basis of the denial in writing.
- I understand that if there is a disagreement as to whether a change should be made, my claim will be noted and included as part of my Confidential Information, and will be included in any subsequent disclosure or dissemination of the disputed data.

_____ _____
Your Signature or Signature of Personal Representative Date

_____
Print Name

Indicate relationship of person signing this form to the individual who is the subject of the information:

___ Person signing is the individual

___ Person signing is the Personal Representative authorized to make health care decisions for the individual. Describe the authority._____

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DPH Use Only

DPH Response to Your Request:

____ In response to your request, a correction/addendum was made part of your permanent record.

____ Your request was denied; however, your request is made part of your permanent record. Your request was denied because:

[ ] The information was not created by the program or Bureau to which you submitted the request.

[ ] The information is not part of your record as maintained by DPH.

[ ] Based on our review, the information is accurate and complete.

[ ] The information is not available for your inspection pursuant to DPH's policy regarding individual access because: _____

_____

Signature: _____ Date: ___/ ___/ ___

Filing a Disagreement

You have the opportunity to provide a statement of disagreement if DPH denies your request. This statement of disagreement, along with any DPH response, will be included in your record, and will be included in any subsequent disclosure or dissemination of the disputed data. Please file any statement of disagreement with the program or Bureau to which you submitted the original request for amendment. You will be provided with a copy of any DPH response to your statement of disagreement

DPH is required to inform you of your right to file a complaint with this decision.

With DPH:
Privacy Office
Massachusetts Department of Public Health
250 Washington St.
Boston, MA 02108
Phone: 617-624-6083

With the Department of Health & Human Services:
Regional Manager, Office for Civil Rights
DHHS Government Center
J.F. Kennedy Federal Building – Room 1875
Boston, Massachusetts 02203
Phone: 617-565-1340
FAX: 617-565-3809 TDD: 617-565-1343

Your complaint must be in writing, filed within one hundred eighty (180) days of when you knew or should have known of the denial, and name DPH as the party you are complaining against.